

Patient Information

Patient Name: _____ **Date:** _____

LAST FIRST MI

If the patient is a minor, give name of parent or legal guardian: _____

Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____ Weight: _____ Height: _____

Phone (HOME): _____ (WORK): _____ (CELL): _____

Address: _____ EMAIL: _____

CITY

STATE

ZIP CODE

MEDICAL HISTORY

Date of last Dental Visit: _____ Name of Dentist: _____ Reason for Visit: _____

Whom may we thank for referring you to our practice? _____

Have you ever had any of the following? Please check those that apply:

Have you ever taken an OSTEOPATHIC medication? Y / N

- AIDS
- Allergies
- Fainting
- Aspirin Allergy
- Anemia
- Arthritis
- Artificial Joints _____
- Asthma
- Blood Disease
- Cancer
- Codeine Allergy
- Diabetes: Type _____
- Dizziness
- Drug Addiction
- Emphysema
- Epilepsy
- Excessive Bleeding
- Mitral Valve Prolapse
- Glaucoma
- Growths
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis _____
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Leukemia
- Mental Disorders
- Tumors
- Nervous Disorders
- Pacemaker
- Penicillin Allergy
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Stomach Problems
- Stroke
- Taking Aspirin Daily
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Med taken? _____
Started: _____
Stopped: _____

(Fosamax/Actonel/Boniva/Aredia/Zometa)

Does dental treatment make you nervous?
 Slightly Moderately Extremely

Would you prefer to be sedated for surgical procedures?
 Yes No

For Women ONLY

Are you taking birth control? Yes No

Are you pregnant? Yes No

Are you allergic to any medication? Have you ever had an allergic reaction to a medication?

If yes, describe: _____

Are you taking any medications at this time? If yes, please list on Medication Information Form.

Have you ever had to pre-medicate with antibiotics for dental treatments? Yes No

Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

Are you now under the care of a physician? Yes No If yes, please explain: _____

Name of Physician: _____ Phone #: _____

Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

Do you use tobacco? Yes No If yes, What and How often? _____

Photographs are sometimes gained from patients' treatment that may be used in clinical presentations; continuing education as well as case review within our office and/or with the patient's referring dentist/doctor.

If you prefer photographs not be taken, please check box. **No photographs**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: _____ Date: _____

Previous Surgeries: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____
Social Security #: _____ Birth Date: _____
Home Phone: _____ Work Phone: _____ Ext: _____
Address: _____
Street _____ Apartment # _____
City _____ State _____ Zip Code _____

Dental Insurance Information

Primary

Name of Insured: _____ Insured's Birth Date: _____
Phone # of Insured: _____ Insured's Social Security #: _____ Relationship to patient: _____
Insured's Address: _____
Insured's Employer: _____
Insurance Plan Name and Address: _____
Insurance Phone #: _____ Insurance Group #: _____

Secondary

Name of Insured: _____ Insured's Birth Date: _____
Phone# of Insured: _____ Insured's Social Security #: _____ Relationship to Patient: _____
Insured's Address: _____
Insured's Employer and Address: _____
Insurance Plan Name and Address: _____
Insurance Phone #: _____ Insurance Group#: _____

Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will file the claims to the insurance companies and help with phone calls to them when necessary. All quotes given from insurance companies are just estimates and are NEVER a guarantee of payment. This office will send pre-estimates to the insurance companies if requested by patient. Patient's estimated co-pay will be due at the date of service unless other arrangements have been made. Any claim not paid within 45 days of the date of service will then be the patient's responsibility. The balance not paid by the insurance will be due by the patient.

----I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

----I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

----I understand that I am completely responsible for the payment of all expenses incurred. I assign and authorize Finley Periodontics, P.L.L.C. payment of any and all benefits payable by Insurance and the necessary release of medical information needed to process all insurance claims. In the event of non-payment I agree to bear the cost of collection and/or court costs and reasonable legal fees not to exceed 50% of the unpaid balance. The undersigned waives rights of exemption under the state of Louisiana. Payment is required at the time of service!

I hereby authorize any treatment deemed necessary by James M. Finley, D.M.D., M.S.

(Patient Signature/ Responsible Party)

(Date)